PATIENT DATA BASE

SECTION I **Please complete this form concerning your health. The information you provide will be used to assist us in planning your care.**

1. What problem(s) brought you to the hospital? What do you know about this condition? _____

_____

2. What are you most concerned about right now? What are your expectations of this admission? _____

_____

3. What significant health problems have you had? _____

_____

4. Have you ever been hospitalized before? ☐ No ☐ Yes When? _____
Why? _____

5. Do you have allergies to any of the following? If so, please list and explain type of reaction.

Medicines No ☐ Yes ☐ _____
Foods No ☐ Yes ☐ _____
Tape No ☐ Yes ☐ _____
Latex No ☐ Yes ☐ _____
Other No ☐ Yes ☐ _____

6. Do you have any special dietary requirements/restrictions? No ☐ Yes ☐ (please explain) _____

_____

7. Please check the activities with which you need assistance:

☐ bathing ☐ eating ☐ walking ☐ dressing ☐ toileting

Explain: _____

_____

8. I require the following items:		I have these items with me:	I do not have these items with me:
☐	contact lenses	☐	☐
☐	glasses	☐	☐
☐	hearing aid(s)	☐	☐
☐	dentures	☐	☐
☐	artificial limb	☐	☐
☐	ostomy equipment	☐	☐
☐	wheelchair	☐	☐
☐	walker/cane	☐	☐
☐	other: _____	☐	☐

Do you require help to care for or use any of these items? ☐ No ☐ Yes If yes, please comment: _____

_____

10. Do you have a permanent pacemaker? ☐ No ☐ Yes Type: _____ Settings _____

Addressograph

11. Are you retired? ☐ Yes ☐ No

Are you employed? ☐ Yes ☐ No

What is your occupation? _____

Are you on active duty? ☐ No ☐ Yes, list command _____

12. Do you have difficulty understanding/speaking/reading English? If so, what is your primary language?

_____

13. Will there be someone to care for you when you are discharged? ☐ Yes ☐ No, I will need assistance

☐ No, but I have made arrangements for assistance (list) _____

14. When you return home, will your current housing arrangements be difficult for you (stairs, etc.)? ☐ No ☐ Yes

If yes, please explain _____

15. Do you have any specific needs that require assistance during your hospitalization, or after your discharge?

☐ No ☐ Yes (list) _____

16. Do you have any religious or cultural beliefs that will impact your hospitalization? ☐ No ☐ Yes

If yes, please comment _____

Would you like to see the Chaplain while you are here? ☐ No ☐ Yes

17. What is the highest level of education you have completed? _____

18. Is there anything that interferes with your ability to follow health advice or your medication schedule (childcare, religion, language barriers, etc)? ☐ No ☐ Yes (explain) _____

19. Do you have any current stresses in your life that may hinder your healing process (job, finances, marriage, children, etc.)? ☐ No ☐ Yes (list) _____

20. What support systems do you have (family, friends, Ombudsman, etc.)? _____

21. Are you currently assisted by any community service (Maternal Support Service, WIC, etc.)? ☐ No

☐ Yes (list) _____

22. Do you use, or have you used, tobacco products? ☐ No ☐ Yes, quit date _____ ☐ Yes, currently

If yes, indicate ☐ cigarettes/cigars ☐ pipe ☐ chew How much? _____ per day How long? _____ years

Do you live with someone who smokes? ☐ No ☐ Yes

Would you like information on smoking cessation? ☐ No ☐ Yes

23. Do you drink alcohol? ☐ No ☐ Yes How much? _____ For how long? _____

When was your last drink? _____ Would you like information on how to quit? ☐ No ☐ Yes

24. Do you use, or have you used, recreational drugs (including marijuana)? ☐ No ☐ Yes

If yes, what have you used? _____

How long have you used? _____

Would you like information on how to quit? ☐ No ☐ Yes

25. Are you in a relationship with a person who physically/verbally/psychologically hurts or threatens you?

☐ No ☐ Yes If yes, please comment _____

_____

Name two people to contact if necessary.

NAME RELATIONSHIP PHONE NUMBER

_____

_____

Please place a check mark in the box next to each symptom or problem you are having. Please explain the nature and the duration of the problem. If you have not having any problems, check NO DIFFICULTY.

Breathing: ☐ NO DIFFICULTY

☐ coughing ☐ difficulty breathing ☐ wheezing ☐ pain ☐ shortness of breath

☐ loud snoring ☐ other Explain: _____

Circulation and Heart: ☐ NO DIFFICULTY

☐ palpitations ☐ chest pain ☐ dizziness ☐ headache ☐ fainting ☐ swelling

☐ excessive bruising ☐ other Explain: _____

Stomach/Bowels: ☐ NO DIFFICULTY

☐ nausea/vomiting ☐ constipation ☐ diarrhea ☐ pain ☐ bleeding

☐ difficulty chewing ☐ difficulty swallowing ☐ indigestion ☐unintentional weight loss/gain > 10 lbs

☐ other Explain: _____

Bladder/Kidney: ☐ NO DIFFICULTY

☐ trouble holding urine ☐ burning ☐ bloody urine ☐ frequency ☐ color change ☐ pain/pressure

☐ difficulty starting or maintaining stream ☐ Other

Explain: _____

Muscles/Bones: ☐ NO DIFFICULTY

☐ cramping ☐ trouble moving/stiffness ☐ aches/pains ☐ weakness ☐ swelling

☐ other Explain: _____

Reproductive: ☐ NO DIFFICULTY

☐ bleeding ☐ discharge ☐ pain ☐ sexual dysfunction ☐ other

Explain: _____

Skin: ☐ NO DIFFICULTY

☐ sores ☐ rash ☐ lumps ☐ changes in moles ☐ excessive perspiration

☐ excessive dryness/cracking ☐ other

Explain: _____

Nerves: ☐ NO DIFFICULTY

☐ numbness ☐ paralysis ☐ tingling ☐ tremors ☐ poor coordination ☐ forgetfulness

☐ seizures/convulsions ☐ other

Explain: _____

Vision/Hearing/Speech: ☐ NO DIFFICULTY

☐ blurred/double vision ☐ light sensitivity ☐ difficulty seeing ☐ voice changes

☐ difficulty hearing ☐ ringing in ears ☐ difficulty speaking ☐ pain/pressure

☐ other Explain: _____

Emotional: ☐ NO DIFFICULTY

☐ anxiety/nervousness ☐ tension ☐ depression ☐ irritability ☐ restlessness

☐ difficulty sleeping ☐ other

Explain: _____

Pain: ☐ NO DIFFICULTY

☐ ACUTE ("short term" pain due to illness, surgery, injury, or combination) ☐ CHRONIC ("long term" pain)

If so: Where do you feel the pain? _____ For how long? _____

Describe the quality of the pain (sharp, throbbing, dull, stinging, tingling, etc.) _____

On a scale of 1 (slight pain) to 10 (worst pain imaginable), what number do you give your pain right now? _____

Using the same scale, what is the worst that this pain gets? _____ What is the best this pain gets? _____

If 0 = no pain and 10 = worst pain imaginable, what is an acceptable number for you? _____

What do you normally do to relieve the pain (medications, rest, heat, cold, etc.)? _____

_____

What makes it worse? _____

Is there any additional information about your health that you would like to give us? ☐ No ☐ Yes

Explain: _____

_____

Signature: _____ Date: _____ Time: _____

SECTION II Admission Nursing Assessment (To be completed by a Registered Nurse)

I reviewed the above information and used information from the following sources in determining the nursing assessment: ☐ History ☐ Physical Assessment ☐ Progress Notes ☐ Outpatient Medical Record

Patient is assessed to be at risk for: ☐ Fall ☐ Skin Breakdown ☐ Nutritional Deficit

☐ Other: _____

Priorities for Care: ☐ Pain Management ☐ Infection Control ☐ Education ☐ Falling Star protocol

☐ Other: _____

Any referrals indicated at this time? ☐ No ☐ Yes, see Multidisciplinary Patient Education Documentation Record

Signature: _____ Date: _____ Time: _____

SECTION III Discharge Nursing Assessment (To be completed by a Registered Nurse)

☐ Pain well managed ☐ No signs/symptoms of infection

☐ Educational needs met ☐ Verbalized understanding ☐ Performed return demonstration on: _____

Referrals pending ☐ No ☐ Yes (list): _____

Signature: _____ Date: _____ Time: _____